Methods and Standards for Establishing Payment Rates – Other Types of Care

I. Drugs

A. Reimbursement

1. Participating pharmacies are reimbursed for the cost of the drug plus a dispensing fee. Payments shall not exceed the upper limits specified in 42 CFR 447.331 through 447.334

2. Participating dispensing physicians are reimbursed for the cost of the drug only.

3. Providers will be reimbursed only for drugs supplied from pharmaceutical manufacturers who have signed a rebate agreement unless the Department has determined that it is in the best interest of Medicaid recipients to make payment for non-rebated drugs.

B. Payment Limits – Payment for the cost of drugs shall be the lesser of:

1. The Federal Maximum Allowable Cost (FMAC) of the drug for multiple source drugs other than those brand name drugs for which a prescriber has certified in writing as "brand medically necessary" or "brand necessary";

2. The Estimated Acquisition Cost (EAC) of the drug that has been established by the Department to be equal to the average wholesale price (AWP) minus twelve (12) percent ; or,

3. The provider's usual and customary charge.

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C. Dispensing Fee

1. The Department established dispensing fees based upon the conclusions of an annual dispensing fee study, which is required by state law. The current dispensing fee is $4.51. The dispensing fee is applied to outpatient pharmacies and to long term care facilities.

   For nursing facility residents meeting Medicaid patient status an add-on of two (2) cents per unit dose for unit dose drugs packaged in unit dose form by the manufacturer and four (4) cents per unit dose for unit dose drugs packaged in unit dose form by the pharmacists, shall be permitted.

2. The fee amount is based on a survey of pharmacy dispensing costs in the Commonwealth of Kentucky, a review of academic literature, and the reimbursement rates of other payers. The dispensing fee established will reimburse the reasonable costs of dispensing prescription drugs incurred by pharmacies in the aggregate.

1. For nursing facility residents meeting Medicaid patient status criteria, there shall be no more than one (1) dispensing fee allowed per drug within a calendar month for maintenance drugs (as determined by the Medicaid agency) and no more than two (2) dispensing fees allowed per drug within a calendar month for other drugs, except for Schedules II, III, and IV controlled substances and for non-solid dosage forms, including topical medication preparations, for which no more than four (4) dispensing fees per drug shall be paid within a calendar month. For nursing facility residents not meeting Medicaid patient status criteria and non-residents of nursing facilities, there shall be no more than one (1) dispensing fee allowed per drug per calendar month for drugs classified by the Medicaid program as maintenance drugs and no more than four (4) dispensing fees shall be allowed per drug within a calendar month for legend intravenous drugs. (Though dispensing fees are limited, this shall not be construed as placing a limit on the quantity of reimbursable drugs for which the program will pay for any patient, since the reasonable cost of the drug (as defined herein) is reimbursable as a covered service in whatever quantity is considered medically necessary for the patient. Non-solid dosage forms include all covered drug items other than oral tablets or capsule forms.)

2. For nursing facility residents meeting Medicaid patient status criteria, an addition to the usual dispensing fee of five (5) dollars and seventy-five (75) cents shall be made for drugs dispensed through the pharmacy outpatient drug program in the amount of two (2) cents per unit dose for unit dose drugs packaged in unit dose form by the manufacturer and four (4) cents per unit dose for unit dose drugs packaged in unit dose form by the pharmacist.

D. Reevaluation of Professional Fee

The professional (dispensing) fee is reevaluated by the program at intervals. To assist in the reevaluation, the state shall periodically conduct surveys of costs of pharmacy operation, including such components as overhead, professional services, and profits.

E. Drugs for Inpatients Receiving Nursing Facility Care

Drugs provided to inpatients in nursing facilities will be paid for in accordance with the reimbursement provisions contained herein except that reimbursement for drugs provided to patients in nursing facility brain injury units and nursing facility ventilator dependent units shall be as a part of the all inclusive rate for the unit and the payments for such drugs shall be in accordance with the MAC/EAC upper limits.

II. Physician Services

A. Definitions

(1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.

(2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.

(3) "Medical School Faculty Physician" is a physician who is employed by a state-supported school of medicine that is part of a university health care system that includes:

(a) a teaching hospital; and
(b) a state-owned pediatric teaching hospital; or
(c) an affiliation agreement with a pediatric teaching hospital.

B. Reimbursement

(1) Payment for covered physicians' services shall be based on the physicians' usual and customary actual billed charges up to the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS).

(2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

(2) RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors are as follows:

Types of Service	Kentucky Conversion Factor
Deliveries	Not applicable
Anesthesia (except delivery related)	$29.02
All Other Services	$29.67

C. Reimbursement Exceptions.

(1) Physicians will be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the Vaccines for Children Program to provide immunizations for Medicaid recipients under the age of twenty-one (21), with reimbursement for the cost of the drugs made by the Department for Medicaid Services to the Department for Public Health upon receipt of notice from the physicians that the drugs were used to provide immunizations to Medicaid recipients.

(2) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

Delivery only	$870.00
Vaginal delivery including postpartum care	$900.00
Cesarean delivery only	$870.00
Cesarean delivery including postpartum care	$900.00

(3) For delivery-related anesthesia services provided on or after July 1, 1995, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Vaginal delivery	$200.00
Epidural single	$315.00
Epidural continuous	$335.00
Cesarean section	$320.00

(4) Payment for individuals eligible for coverage under Medicare Part B is made, in accordance with Sections A and B and items (1) through (4) and (6) of this section within the individual's Medicare deductible and coinsurance liability.

(5) For services provided on or after July 1, 1990, family practice physicians practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the physicians' usual and customary actual billed charges up to 125 percent of the fixed upper limit per procedure established by the Department.

(6) For services provided on or after July 1, 1990, physician laboratory services shall be reimbursed based on the Medicare allowable payment rates. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.

(7) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the physician's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.

(8) Payments for the injection procedure for chemonucleolysis of invertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or at a fixed upper limit of $793.50 as established by the Department.

(9) Specified family planning procedures performed in the physician office setting shall be reimbursed at the lesser of the actual billed charge or the established RBRVS fee plus actual cost of the supply minus ten percent.

(10) Certain injectable anitbiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.

(11) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).

(12) For a practice-related service provided by a physician assistant, the participating physician shall be reimbursed at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the Department for Medicaid Services at seventy-five (75) percent of the physician's fixed upper limit per procedure.

(13) Any physician participating in the lock-in program will be paid a $10.00 per month lock-in fee for provision of patient management services for each recipient locked-in to that physician.

(14) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents who have entered into contractual agreements with medical schools for the assignment of payments in accordance with 42 CFR 447.10.

(15) The supplemental payments will be made on a quarterly basis in an amount which when combined with other payments under the plan, does not exceed the physicians' usual and customary charges.

D. Assurances. The state hereby assures that (1) payment for physician services are consistent with efficiency, economy, and quality of care (42 CFR 447.200); and (2) payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances (42 CFR 447.325).

III. Dental Services

A. Definitions.

For purposes of determination of payment usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.

"Dental School Faculty Dentist" is a dentist who is employed by a state-supported school of dentistry.

B. Reimbursement for Outpatient and Inpatient Services.

(1) The department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients at the dentist's actual billed charge not to exceed the fixed upper limit per procedure established by the department.

(2) With the exceptions specified in section (3), (4), and (5), the upper payment limit per procedure shall be established by increasing the limit in effect on 6/30/00 by 32.78%, rounded to the nearest dollar. This rate of increase is based upon an allocation of funds by the 2000 Kentucky General Assembly and a comparison to rates of other states based upon a survey of Dental Fees by the American Dental Association.

(3) If an upper payment limit is not established for a covered dental service in accordance with (2) above, the department shall establish an upper limit by the following:

a. The state will obtain no less than three (3) rates from other sources such as Medicare, Workmen's Compensation, private insurers or three (3) high volume Medicaid providers:
b. An average limit based upon these rates will be calculated; and
c. The calculated limit will be compared to rates for similar procedures to assure consistency with reimbursement for comparable services.

(4) The following reimbursement shall apply:

a. Orthodontic Consultation, $112.00, except that a fixed fee of $56.00 shall be paid if:

1. The provider is referring a recipient to a medical specialist;
2. The prior authorization for orthodontic services is not approved; or
3. A request for prior authorization for orthodontic services is not made.

b. Prior authorized early phase orthodontic services for moderately severe disabling malocclusions, $1,367 for orthodontists and $1,234 for general dentists..

c. Prior authorized orthodontic services for moderately severe disabling malocclusions, $1,825 for orthodontists and $1,649 for general dentists.

d. Prior authorized orthodontic services for severe disabling malocclusions, $2,754 for orthodontists and $2,455 for general dentists.

e. Prior authorized services for Temporomandinbular Joint (TMJ) therapy, an assessed rate per service not to exceed $424.

(5) This reimbursement methodology does not apply to oral surgeons' services that are included within the scope of their licenses. Those services are reimbursed in accordance with the reimbursement methodology for physician services.

(6) Medicaid reimbursement shall be made for medically necessary dental services provided in an inpatient or outpatient setting if:

a. The recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if provided in a dentist's office; and

b. In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in an inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

(7) In addition to payment for services as provided in this section, the department makes supplemental payments for services provided by dental school faculty either directly or as a supervisor of a dental resident. The supplemental payments are subject to funds available for this purpose and will be made on a quarterly basis in an amount when combined with other payments under the plan, do not exceed the dentist's usual and customary charges.

Preauthorized early phase orthodontic services for moderately severe or severe handicapping malocclusion, $1,200 for orthodontists and $1,080 for general dentists;

Preauthorized orthodontic services for moderately severe handicapping malocclusions, $1,600 for orthodontists and $1,440 for general dentists;

Preauthorized orthodontic services for severe handicapping malocclusions, $2,400 for orthodontists and $2,160 for general dentists;

(3) This reimbursement methodology does not apply to oral surgeons' services which are included within the scope of their oral surgery licenses. Those services are reimbursed as physicians' services rather than dentists' services.

(4) Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

IV. Vision Care Services

A. Definitions.

For purposes of determination of payment, "usual and customary actual billed charge" refers to the uniform amount the individual optometrist or ophthalmic dispenser charges in the majority of cases for a specific procedure or service.

B. Reimbursement for Covered Procedures and Materials for Optometrists.

(1) Reimbursement for covered services, within the optometrist's scope of licensure, except materials and laboratory services, shall be based on the optometrists' usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS). Fixed upper limits not determined in accordance with the RBRVS methodology (due to factors such as availability) shall be set by the department using the following methodology.

The fixed upper limit for the procedure shall be consistent with the general array of rates for the type of service. "General array of fixed rates" means that the rate upper limit set for the procedure will be at the same relative level, so far as possible, as the rates for procedures which are similar in nature. The listing of similar services is referred to as the "general array." The actual upper limit is derived by using not less than 3 other sources such as Medicare, Workman's Compensation, other federal programs, other state or local governments, and health insurance organizations or if a rate is not available from these sources then we solicit rates from at least 3 of the highest volume instate providers of the services. After obtaining at least 3 rates, the rates are added together then divided by the number of rates to obtain an average rate which is then compared to similar procedures paid in comparable circumstances by the Medicaid program to set the upper limit.

(2) With the exception of rates paid for dispensing services, fixed upper limits for vision services shall be calculated using the same RBRVS units as those used in the physicians services program, with the units multiplied by the "all other services" conversion factor to arrive at the fixed upper limit for each procedure.

(3) The upper payment limit for the following dispensing services shall be established by increasing the limit in effect on 6/30/00 to a fee no less than the Medicare allowable fee established for the service

(a) Fitting of spectacles;
(b) Special spectacles fitting; and
(c) Repair and adjustment of spectacles.

(4) Reimbursement for materials (eyeglasses or parts of eyeglasses) shall be made at the optical laboratory cost of the materials not to exceed upper limits for materials as set by the department. An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for post-payment review. The agency upper limits for materials are set based on the agency's best estimate of reasonable and economical rates at which the materials are widely and

consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometry Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

(5) Laboratory services shall be reimbursed at the actual billed amount not to exceed Medicare allowable reimbursement rates. If there is no established Medicare allowable reimbursement rate, the payment shall be sixty-five (65) percent of usual and customary actual billed charges.

C. Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers

Reimbursement for a covered service within the ophthalmic dispenser's scope of licensure shall be as described in Section B (above).

D. Effect of Third Party Liability

When payment for a covered service is due and payable from a third party source, such as private insurance, or some other third party with a legal obligation to pay, the amount payable by the department shall be reduced by the amount of the third party payment.

F. Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

V. Hearing Services

A. The State Agency shall reimburse a participating audiologist at usual and customary actual billed charges up to the fixed upper limit per procedure established by the State Agency at sixty-five (65) percent of the median billed charge using 1989 calendar year billed charges. If there is no median available for a procedure, or the State Agency determines that available data relating to the median for a procedure is unreliable, the State Agency shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. ("General array of fixed upper limits" means that the rate upper limit set for the procedure will be at the same relative level, so far as possible, as the upper limits for procedures which are similar in nature; the listing of similar services is what we referred to as a "general array.") Payment for a hearing aid furnished by the audiologist is reimbursed in the same manner as a hearing aid dealer.

Audiologists shall be entitled to the same dispensing fee or hearing aids as shown in Section B. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

B. Hearing Aid Dealers.

1. If the manufacturer of the hearing aid billed to the program has submitted a dealer price schedule which includes that hearing aid, the State Agency shall reimburse the participating hearing aid dealer at the lesser of:

a) That dealer price in the price schedule plus seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when the two hearing aids are dispensed on the same date;

b) Actual dealer cost plus a professional fee of seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date; or

c) The suggested retail price submitted by the manufacturer for that aid.

2. If the manufacturer of the hearing aid billed to the program has not submitted a dealer price schedule which includes that hearing aid, the State Agency shall reimburse that participating hearing aid dealer at the lessers of:

a) The lowest dealer price submitted for a comparable hearing aid plus a professional fee of seventy-five (75) dollars or at the actual dealer cost plus a professional fee of seventy-five (75) dollars or twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date;

b) The actual dealer cost plus a professional fee of seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date; or

c) The lowest suggested retail price submitted for a comparable aid. A comparable aid is defined as an aid falling within the general classification of fitting type, i.e., body, behind-the-ear, in-the-ear, eyeglasses.

c. Cords. The State Agency shall make payment for a replacement cord at the dealer's cost, plus professional fee set at the fixed upper limit

D. Hearing Aid Repairs. The State Agency shall reimburse a hearing aid dealer for a hearing aid repair on the basis of the manufacturer's charge for repair or replacement of parts, plus the dealer's cost for postage and insurance relative to the repair, plus a professional fee set at the fixed upper limit.

VI. Screening Services

A. The state agency shall reimburse individual providers for screening services in accordance with their usual payment procedures outlined in this state plan.

B. The state agency shall reimburse screening clinics or agencies on the basis of a pre-established fee which shall be related to the cost of service as follows:

(1) For a complete screening which includes all items or procedures appropriate to age and health history of the recipient, except the fifth year (kindergarten examination)and twelfth year (sixth grade examination), the fee shall be seventy (70) dollars per recipient screened;

(2) For a complete screening for the fifth and twelfth years, the fee shall be ninety (90) dollars per recipient screened;

(3) For a partial screening, which shall include at least a health history and unclothed physical examination, the fee shall be thirty (30) dollars per recipient screened;

(4) For completion of a partial screening with some items or procedures appropriate to age and health history of the recipient provided as a follow-up to a partial screening, the fee shall be forty (40) dollars per recipient screened.

(5) For an interperiodic screen, which shall be medically necessary to determine the existence of a suspected physical or mental illness and in addition to the regular periodicity scheduled screenings, the fee shall be thirty (30) dollars per recipient screened.

(6) In no instance may the fee paid in accordance with items (1) through (5) exceed the usual and customary fee of the provider for the service.

VI-A. Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

(1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services) the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:

(a) 1905(a)(1), inpatient hospital services;
(b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
(c) 1905(a)(3), other laboratory and X-ray services;
(d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
(e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
(f) 1905(a)(6), medical care by other licensed practitioners;
(g) 1905(a)(7), home health care services;
(h) 1905(a)(9), clinic services;
(i) 1905(a)(10), dental services;
(j) 1905(a)(11), physical therapy and related services;
(k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
(l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
(m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
(n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
(o) 1905(a)(17), nurse-midwife services;
(p) 1905(a)(18), hospice care;
(q) 1905(a)(19), case management services; and
(r) 1905(a)(~~21~~ 22), other medical and remedial care specified by the Secretary. P&I HCFA 5-15-92

(2) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21 the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100% of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

(a) Any service described in 1, above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
(b) 1905(a)(8), private duty nursing services;
(c) 1905(a)(20), respiratory care services;
(d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and
(e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitoriums, and personal care services in a recipient's home.

VII. Transportation Services

A. Ambulance Services

(1) The department shall reimburse an ambulance service at the lesser of the provider's usual and customary charge or an upper limit established by the department for the service. Payment for an ambulance service shall be contingent upon a statement of medical necessity.

(2) The upper limit for air ambulance transportation shall be set at $3,500 per one (1) way trip.

(3) The upper limit for an ambulance service (other than air ambulance transportation) shall be calculated by adding a base rate, mileage allowance, and flat rate fee as follows:

(a) The base rate for Advanced Life Support (ALS) emergency ambulance transportation to the emergency room of a hospital shall be set at $100 per one (1) way trip; the mileage allowance for trips shall be four (4) dollars per mile for mileage from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional allowance for mileage.

(b) The base rate for Basic Life Support (BLS) emergency ambulance transportation to the emergency room of a hospital shall be set at seventy-five (75) dollars per one (1) way trip; the mileage allowance for trips shall be three (3) dollars per mile for mileage from mile one (1); a flat rate of twenty (20) dollars shall be set for each additional recipient with no additional allowance for mileage.

(c) The base rate for any ALS or BLS providing emergency ambulance transportation to an appropriate medical facility or provider other than the emergency room of a hospital shall be set at fifty-five (55) dollars per one (1) way trip; the mileage allowance for trips shall be two (2) dollars and fifty (50) cents per mile for mileage from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage.

(d) The base rate for BLS emergency ambulance transportation to the emergency room of a hospital during which the services of an ALS Medical First Response provider is required to stabilize the patient shall be $100; the mileage allowance shall be four (4) dollars per mile from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional rate for mileage.

(e) The base rate for BLS emergency ambulance transportation to a medical facility or provider other than the emergency room of a hospital during which the services of an ALS Medical First Response provider are required shall be fifty-five (55) dollars; the mileage allowance shall be two (2) dollars and fifty (50) cents per mile from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage.

(f) The base rate for non-emergency ambulance transportation during which the recipient requires no medical care during transport shall be fifty (50) dollars and the mileage allowance shall be two (2) dollars per mile from mile one (1).

(g) The cost of other itemized supplies for ALS or BLS emergency transportation services shall be the actual cost as reflected on the transportation provider's invoice which shall be maintained in the provider's files and shall be produced upon request by the department. Each quarter, the department shall review a random sample of invoices to verify reported costs.

(4) In addition to the rates described in paragraph (3) above, administration of oxygen during an ambulance transportation service (other than air ambulance transportation) shall be reimbursed at a flat rate of ten (10) dollars per one (1) way trip when medically necessary.

(5) Reimbursement for an ambulance service shall not be made if a recipient has paid a membership or subscription fee to a transportation provider in order to access a free or discounted ambulance transportation service.

B. Commercial Transportation Carriers
The department shall reimburse participating commercial transportation carriers at usual commercial rates with limitations as follows:

(1) For taxi services provided in regulated areas the provider shall be reimbursed the normal passenger rate charged to the general public for a one (1) way trip regardless of the number of Medicaid eligible recipients transported when the trip is within the medical service area. The taxi shall be paid the single passenger rate regardless of the number of additional passengers.

(2) For taxi services in those areas of the state where taxi rates are not regulated by the appropriate local rate setting authority, and for taxi services in regulated areas when they go outside the medical service area, the provider shall be reimbursed the normal passenger rate charged the general public for a single passenger (without payment for additional passengers, if any) up to the upper limit; reimbursement for transport of a parent or attendant shall be considered included within the upper limit allowed for the trip. The upper limit for a taxi transporting a recipient shall be:

(a) The usual and customary charge up to a maximum of six (6) dollars for trips of five (5) miles or less, one (1) way, loaded miles.

(b) The usual and customary charge up to a maximum of twelve (12) dollars for trips of six (6) to ten (10) miles, one (1) way, loaded miles.

(c) The usual and customary charge up to a maximum of twenty (20) dollars for trips of eleven (11) to twenty-five (25) miles, one (1) way, loaded miles.

(d) The usual and customary charge up to a maximum of thirty (30) dollars for trips of twenty-six (26) miles to fifty (50) miles, one (1) way, loaded miles.

(e) For trips of fifty-one (51) miles or above shall be the lesser of the usual and customary charge or an amount derived by multiplying one (1) dollar by the actual number of miles, not to exceed a maximum of seventy-five (75) dollars per trip, one (1) way, loaded miles.

C. Private Automobile Carriers.

(1) The department shall reimburse private automobile carriers at the basic rate of twenty-two (22) cents per mile plus a flat fee of four (4) dollars per recipient if waiting time is required. For round trips of less than five (5) miles the rate shall be computed on the basis of a maximum allowable fee of six (6) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. Private automobile carriers shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing reimbursable medical transportation services.

(2) For round trips of five (5) to twenty-five (25) miles the rate for private automobile carriers shall be computed on the basis of maximum allowable fee of ten (10) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. The maximum allowable fee rates shall not be utilized in situations where mileage is paid.

(3) Even though the maximum allowable fee rate when computed on the basis of twenty-two (22) cents per mile plus four (4) dollars for waiting time would not equal the six (6) dollars or ten (10) dollars allowable amounts, the higher amount is paid to encourage private automobile carriers to provide necessary medical transportation. Additionally, nothing in this section requires the department to pay the amounts specified if the private automobile carrier expresses a preference for reimbursement in a lesser amount; then the lesser amount shall be paid. Toll charges shall be reimbursable when presented with a receipt.

(4) Waiting time shall be a reimbursable component of the private automobile carrier transportation fee only if waiting time occurs. If waiting time occurs due to admittance of the recipient into the medical institution, the private automobile carrier may be reimbursed for the return trip to the point of recipient pick-up as though the recipient were in the vehicle; that is, the total reimbursable amount shall be computed on the basis of the maximum allowable fee or mileage rate plus waiting time. Waiting time shall not be paid for the attendant or caretaker relative (e.g., mother, father) who is accompanying the recipient and not personally being transported for Medicaid covered service.

(5) If a private automobile carrier is transporting more than one (1) recipient, only one (1) mileage payment shall be allowed. Mileage shall be computed on the basis of the distance between the most remote recipient and the most remote medical service utilized; and will include any necessary additional mileage to pickup and discharge the additional recipients.

D. Non-Commercial Group Carriers.

(1) The department shall reimburse participating non-commercial group carriers based on actual reasonable, allowable cost to the provider based on cost data submitted to the department by the provider.

(2) The minimum rate shall be twenty (20) cents per recipient per mile transported and the rate upper limit shall be fifty (50) cents per recipient per mile transported.

(3) Payment for a parent or other attendant shall be at the usual recipient rate.

E. Specialty Carriers.

(1) Participating specialty carriers shall be reimbursed at the lesser of the following rates:

(a) The actual charge for the service; or

(b) The usual and customary charge for that service by the carrier, as shown in the schedule of usual and customary charges submitted by the carrier to the department; or

(c) The program maximum established for the service.

(2) Program maximums shall be:

(a) For nonambulatory recipients who require the use of a wheelchair, the upper limit shall be twenty-five (25) dollars for the first recipient plus four (4) dollars for each additional nonambulatory recipient transported on the same trip, for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollar and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and certified; mileage charges shall not be allowed for additional recipients.

(b) For ambulatory recipients who are disoriented, the upper limit shall be twelve (12) dollars and fifty (50) cents for the first recipient plus four (4) dollars for each additional disoriented recipient transported on the same trip for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollars and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and verified; mileage charges shall not be allowed for additional recipients.

(c) For both paragraphs (a) and (b) of this section, empty vehicle miles shall not be included when computing allowable reimbursement for mileage.

(3) Reimbursement shall be made at specialty carrier rates for the following types of recipients only:

(a) Nonambulatory recipients who need to be transported by wheelchair, but shall not include recipients who need to be transported as stretcher patients; and

(b) Ambulatory recipients who are disoriented.

(4) The specialty carrier shall obtain a statement from the recipient's physician (or, if the recipient is in a nursing facility, from the director of nursing, charge nurse, or medical director in lieu of physician) to verify that transportation by the specialty carrier is medically necessary due to the recipient's nonambulatory or disoriented condition. Claims for payment which are submitted without the required statement of verification shall not be paid.

F. Specially authorized transportation services authorized in unforeseen circumstances may be paid for at a rate adequate to secure the necessary service; the amount allowed shall not exceed the usual and customary charge of the provider. The Department for Medicaid Services shall review and approve or disapprove requests for specially authorized transportation services based on medical necessity.

G. Use of flat rates.

Transportation payment shall not exceed the lesser of six (6) dollars per trip, one (1) way (or twelve (12) dollars for a round trip), or the usual fee for the participating transportation provider computed in the usual manner if:

(1) The recipient chooses to use a medical provider outside the medical service area; and

(2) The medical service is available in the recipient's medical service area; and

(3) The recipient has not been appropriately referred by the medical provider within his medical service area.

H. Meals and Lodging.

The flat rate for meals and lodgings for recipients and attendants when preauthorized (or post-authorized if appropriate) by the department shall be as follows:

(1) Standard Area:

(a) Meals: breakfast-$4 per day; lunch-$5 per day; dinner-$11 per day; and

(b) Lodgings: $40 per day

(2) High Rate Area:

(a) Meals: breakfast-$5 per day; lunch-$6 per day; dinner-$15 per day; and

(b) Lodgings: $55 per day.

I. Limitations.

(1) Any reimbursement for medical transportation shall be contingent upon the recipient receiving the appropriate preauthorization or postauthorization for medical transportation as required by the Department for Medicaid Services.

(2) (a) Authorization shall not be granted for recipients transported for purposes other than to take the recipient to or from covered Medicaid services being provided to that recipient, except in the instance of one (1) parent accompanying a child to or from covered medical services being provided to the child or if one (1) attendant is authorized for a recipient traveling to or from covered medical services based on medical condition of the recipient.

(b) Reimbursement shall be limited to transportation services and shall not include the services, salary or time of the attendant or parent.

(3) An individual who owns a taxi company and who uses the taxi as his personal vehicle shall be reimbursed at the private auto rate when transporting household family members.

(4) Mileage for reimbursement purposes shall be computed by the most direct accessible route from point of pickup to point of delivery.

VIII. Outpatient Hospital Services

A. Effective for services provided on and after April 1, 2001 payments for in-state outpatient hospital services will be made on an interim basis. The interim payments will be calculated by multiplying the hospitals Medicaid billed outpatient service charges by the hospital's facility-specific cost-to-charge ratio. This ratio is determined by dividing its Medicaid allowable cost of covered outpatient services from its most recently settled cost report by the hospital's Medicaid billed charges for covered outpatient services for the same report period. There will be a lower of cost of charges year-end settlement for covered outpatient services.

B. Effective for services provided on and after April 1, 2001, outpatient services provided by an out-of-state hospital will be reimbursed at sixty-five (65) percent of Medicaid billed charges with no settlement to the lower of cost or charges.

Effective for services provided on and after July 2, 2001, out-of-state hospitals will be reimbursed in accordance with the following:

1. Out-of-state hospitals providing in excess of $100,000 in paid claims for the previous year (July 1 to June 30) will be required to submit a copy of their most recent Medicare cost report. On an interim basis for the period of July 1, 2001 to September 1, 2001, reimbursement will be determined based on the Kentucky statewide average cost-to-charge ratio, (i.e., cost-to-charge ratio x billed charges) for in-state hospitals. Once the department receives a cost report, reimbursement will be as described above in VIII. A. Failure to provide the required cost report will result in a reduction of future payments to the lesser of the payment based on the most current cost report data or payment based on the Kentucky statewide average cost-to-charge ratio.

2. Out-of-state hospitals providing less than $100,000 in paid claims for the previous year (July 1 to June 30) will not be required to submit a copy of their most recent Medicare cost report. Reimbursement will be made by multiplying the Kentucky statewide average cost-to-charge ratio x billed charges. Annually, the department will determine the average statewide cost-to-charge ratio for all in-state hospitals.

C. Charges or costs shall not be transferred between the inpatient and outpatient service units.

D. Outpatient hospital laboratory services will be paid based on the Medicare allowable payment rates.

E. Outpatient hospital laboratory services with no established Medicare payment rate will be reimbursed at sixty-five (65) percent of Medicaid billed charges with no settlement to the lower of cost or charges.

F. Supplemental Payments to Non-state Government-owned or Operated Hospitals.

1. The Department provides quarterly supplemental payments to non-state government-owned or operated hospitals for outpatient services provided to Medicaid recipients. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.

2. To qualify for a supplemental payment, a hospital must be a non-state government-owned or operated hospital that has entered into an Intergovernmental Transfer Agreement with the Commonwealth. The payment amount for a qualifying hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all qualifying hospitals for the same fiscal year.

G. Emergency Room Services

1. Effective for services provided on and after September 1, 2002, the Department will reimburse for emergency room services at a flat rate per visit based upon the level of service provided. In addition, diagnostic and radiological procedures will be paid at specific rates.

2. There shall be rates for three (3) levels of service and an assessment fee:
   - Level I shall be those services billed using CPT codes 99281 and 99282, reimbursed at $82.00.
   - Level II shall be those services billed using CPT codes 99283 and 99284, reimbursed at $164.00.
   - Level III shall be those services billed using CPT codes 99285, reimbursed at $264.00
   - An assessment, or triage, shall be payable at $20.00

   Included in the flat rate are pharmacy (except for thrombolytic agents), medical supplies, radiology (except as described in 4 below), laboratory, physical and respiratory therapy, electrocardiogram, and electroencephalogram.

3. The flat rates per visit were calculated in accordance with the following:

   The Level II rate was calculated by multiplying the average costs for Level II services in state fiscal years 2000 and 2001 (adjusted by the moving average of Data Resources, Inc. for the Hospital Market Basket) by .75.

   The Level I rate is established at 50% of the Level II rate.
   The Level III rate is established at $100 higher than the Level II rate.

4. Separate rates were established for the following:

   The rates for treatment procedures including cardiac catheterization and lithotripsy are calculated at 150% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

   The rates for diagnostic procedures including CT scans, ultra sounds, and magnetic reasoning imaging are calculated at 100% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

   The rate for observation are calculated at 100% of the average adjusted costs for state fiscal years 2000 and 2001.

5. Thrombolyptic agents shall be reimbursed at acquisition costs.

X. Home Health Agency Services

(1) The following home health services are reimbursed at the lower of an upper payment limit established by the state Medicaid agency or the actual billed charge:

Skilled Nursing
Home Health Aide
Medical Social Service
Physical, Occupational and Speech Therapy

(2) The payment for enteral nutritional products and disposable medical supplies shall be an interim payment rate established by the state Medicaid agency by calculating the providers total cost to charge ratio for the items as reported on the home health agencies most recent available cost report as of May 31 immediately preceding the rate year. Interim payments shall not exceed the providers charges billed for these items. Interim payments will be settled back to actual cost at the end of the home health agency's fiscal year. Home health agencies that are operated by public providers shall not be settled to the lower of cost or charges. These home health agencies shall be reimbursed their total allowable cost.

(3) Payment to a new home health agency shall be the lesser of billed charges or the statewide upper payment limit established by the state Medicaid agency for all home health services except for enteral nutritional products and disposable medical supplies. Payment to a new home health agency for enteral nutritional products and disposable medical supplies will be seventy (70) percent of the new home health agency's usual and customary actual billed charges. A new home health agency will be held to the seventy (70) percent threshold until a cost report is accepted by the state Medicaid agency no later than May 31 preceding the rate year. Interim payments will be settled back to actual cost at the end of the agency's fiscal year.

(4) Payment to an out of state home health agency shall be the lessor of billed charges or the statewide upper payment limit established by the state Medicaid agency for all home health services except for enteral nutritional products and disposable medical supplies. Payment to an out of state home health agency for enteral nutritional products and disposable medical supplies will be eighty (80) percent of the out of state agency's usual and customary actual billed charges.

XI. Laboratory Services

Eff. 7-1-88 The State Agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics for covered laboratory services rendered on the basis of the allowable payment rates set by Medicare.

XII. (Deleted)

XIII. Family Planning Clinics

Eff. 7-1-87 The State Agency will reimburse participating family planning agencies for covered services in accordance with 42 CFR Section 447.321; payments shall not exceed applicable Title XVIII upper limits. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall not exceed the following amounts:

	Physicians	ARNP
Initial Clinic Visit	$50.00	$37.75
Annual Clinic Visit	$60.00	$45.00
Follow-up Visit with Pelvic Examination	$25.00	$18.75
Follow-up Visit without Pelvic Examination	$20.00	$15.00
Counseling Visit	$13.00	$13.00
Counseling Visit w/3 months contraceptive supply	$17.00	$17.00
Counseling Visit w/6 months contraceptive supply	$20.00	$20.00
Supply Only Visit - Actual acquisition cost of contraceptive supplies dispensed		

XIV. Durable Medical Equipment, Supplies, Prosthetics and Orthotics

1. General DME Items

For DME items that have an HCPC code (except for customized items) reimbursement shall be based on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.

2. Manual Pricing of DME Items

a. Customized items with a miscellaneous HCPC code of K0108 will require prior-authorization and will be reimbursed at invoice plus twenty-two (22) percent, not to exceed the supplier's usual and customary charge.

b. Customized components that do not have an HCPC code will require prior-authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.

c. DME items that do not have HCPC codes will require prior authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.

d. Specialized wheelchair bases will require prior-authorization and will be reimbursed at manufacturers suggested retail price minus fifteen (15) percent, not to exceed the supplier's usual and customary charge.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers and primary care centers shall be reimbursed in accordance with the limitations in 42 CFR 447.321.

A. Community mental health centers.

1. Participating in-state mental health centers shall be reimbursed as follows:

   a. The department shall establish final prospective rates for each direct service cost center using audited annual cost reports for the prior year. If an audited costs report is not available, the most recent unaudited cost report shall be used with the rate adjusted as necessary at the time of audit or desk review.

   b. Cost used in setting the rates shall be trended to the beginning of the rate year and indexed for inflation using the Home Health Agency Market Basket National Forecast.

   c. Direct service costs shall be arrayed and an upper limit set at 130 percent of the median cost per unit.

   d. The base rate per unit shall be the allowable cost or the upper limit, whichever is less.

   e. In addition to the base rate per unit, each center shall receive a cost savings incentive payment equal to fifteen (15) percent of the difference between the facility's allowable cost and the upper limit.

   f. A funding adjustment equal to $1.3 million shall be distributed based on the number of outpatient units of service provided. This adjustment is to improve services and to encourage the provision of additional services.

   g. The reimbursable departmental cost centers are on-site psychiatrist, on-site individual, off-site psychiatrist, off-site individual, group, personal care, therapeutic rehabilitation, inpatient hospital psychiatrist, inpatient hospital other, universal prevention, selective prevention, indicated prevention, outpatient, assessment, day rehabilitation, case management, and community support.

2. Participating out-of-state mental health center providers shall be reimbursed the lower of charges, or the facility's rate as set by the state Medicaid Program in the other state, or the upper limit for that type of service in effect for Kentucky providers.

2. For state fiscal year July 1, 2002 - June 30, 2003, the payment rates for other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers will be the rates that were in effect on June 30, 2002.

Payment methodology for rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and that are provided through an agreement with the State Health or Title V agency.

A. Rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rates for rehabilitative services are negotiated rates between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of each service.

The payment rate for rehabilitative services that are authorized after June 30, 2002, are uniform rates, determined by 98% of the weighted median of claims for each service for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

B. Rehabilitative services for children under the supervision of the state and that are provided through an agreement with the State Health or Title V agency.

Payments for rehabilitative services covered in Attachment 3.1-A, page 7.6.1 and Attachment 3.1B, page 31.5 for the target populations are per service. They are based upon one or more documented rehabilitative services provided to each client. The rates for the rehabilitative services are based upon the actual direct and indirect costs to the providers. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing rehabilitative services based on financial information submitted by the provider.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: identification, by recipient and worker, of each individual service provided, a showing of all direct costs for rehabilitative services; and a showing of all indirect costs for rehabilitative services appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principle if necessary.

Rehabilitative service providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

B. Effective for services provided on and after July 2, 2001, primary care centers will be reimbursed in accordance with the prospective payment system described in Attachment 4.19-B, page 20.16 for FQHCs and RHCs.

For drugs for specified immunizations provided free from the Health Department to primary care centers for immunizations for Medicaid recipients, the cost of the drugs are paid to the Health Department. The specified immunizations are: diphteria and tetanus toxiods and pertuisis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any type(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

Effective January 1, 1989, the cost for these immunizations will not be allowed as a part of the primary care center cost base so long as these drugs are available free from the Health Department.

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XVII. FQHC/RHC Services

Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) shall be made in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA).

For the period of January 1, 2001 through June 30, 2001, the state will implement an alternative reimbursement methodology that is agreed to by the state and the individual center/clinic and results in a payment rate to the center/clinic that is at least equal to the Medicaid PPS rate. The alternative methodology shall be in accordance with the state plan in effect on December 31, 2000.

All FQHCs and RHCs are reimbursed on a prospective payment system beginning with State Fiscal Year 2002 with respect to services furnished on or after July 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the clinic/center's reasonable cost for the clinic/center's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic/center's fiscal year 2001 and increased by an appropriate medical index. These costs are divided by the number of visits/encounters for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for state fiscal year 2002. For each state fiscal year thereafter, each clinic/center will be paid the amount (on a per visit basis) equal to the amount paid in the previous state fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that state fiscal year. The clinic/center must supply a budgeted cost report of the change in service to justify scope of service adjustments.

For newly qualified FQHCs/RHCs after State Fiscal Year 2001, initial payments are established by cost reporting methods. A newly qualified clinic/center shall submit a budgeted cost report from which an interim rate shall be established. After completion of a clinic/center fiscal year, a final PPS rate will be established. After the initial year, payment is set using the MEI methods used by other clinics/centers, with adjustments for increases or decreases in the scope of service furnished by the clinic/center during that fiscal year.

In the case of a FQHC or RHC that contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the center or clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the center or clinic is entitled under the PPS.

Until a prospective payment methodology is established, the state will reimburse FQHCs/RHCs based on the rate in effect on June 30, 2001. This rate is based on the State Plan in effect on June 30, 2001. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

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XVIII. Outpatient Surgical Clinics

Reimbursement will be made to freestanding outpatient surgical clinics on the basis of sixty-five (65) percent of their usual and customary charge for the procedure performed. Payment rates shall not exceed the provider's usual and customary charge to the general public. Hospital based outpatient surgical clinics shall be reimbursed in the same manner as hospital outpatient services.

XIX Nurse-Midwife Services

Participating nurse-midwife providers shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of the nurse-midwife.

For services provided on or after July 1, 1990, payments to nurse-midwives shall be at usual and customary actual billed charges on a procedure-by-procedure basis, with reimbursement for each procedure to be the lesser of the actual billed charge or at seventy-five (75) percent of the fixed upper limit per procedure for physicians.

XX Nurse anesthetist services

Reimbursement will be made at the rate of seventy-five (75) percent of the anesthesiologist's allowable charge for the same procedure under the same conditions, or at actual billed charges if less.

Exception:

For inpatient delivery-related anesthesia services provided on or after December 1, 1988, a nurse anesthetist will be reimbursed the lesser of the actual billed charge or the standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Normal Delivery, $150.00;
Low Cervical C-Section, $202.50;
Classic C-Section, $240.00;
Epidural Single, $236.25;
Epidural Continuous, $251.25;
C-Section with Hysterectomy, subtotal, $240.00;
C-Section with Hysterectomy, total, $240.00;
Extraperitoneal C-Section, $240.00

XXI. Podiatry Services

The cabinet shall reimburse licensed, participating podiatrists for covered podiatry services rendered to eligible Medical Assistance recipients at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the cabinet at 65 percent of the median billed charge for outpatient services and 50 percent of the median billed charge for inpatient services using 1989 calendar year billed charges. If there is no median available for a procedure, or the cabinet determines that available data relating to the median for a procedure is unreliable, the cabinet shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

XXII Hospice Services

Reimbursement for licensed, participating hospices shall be at the rates provided for in Section 9505(c) of Public Law 99-272 (COBRA). In addition, for hospice patients in nursing facility beds participating in the Medicaid Program, the hospice shall be paid an amount for room and board furnished by the facility which is equal to ninety-five (95) percent of the Medicaid rate for the facility.

XXIII. Case Management Services

A. Targeted case management services for severely emotionally disturbed children and adults with chronic mental illness.

Providers are paid a uniform interim rate. The uniform interim rate approximates an average of provider actual costs from the previous year. Prior to July 1, 2002, the uniform interim rate was settled to individual provider actual cost at the end of the state's fiscal year. Providers are required to submit an independently audited cost report as acceptable documentation of actual cost.

The billable unit of service is one month.

For state fiscal year July 1, 2002 - June 30, 2003, the uniform interim rate will be the final rate, and will not be settled to provider actual cost.

B. Targeted case management services for children with developmental disabilities provided through an agreement with the Title V Agency.

Payments for case management services are on a per encounter or per item basis. Payments shall be based on documented costs for the direct provision of services. Documented costs do not include payment for administrative and indirect overhead costs of the Title V agency or its contractor state agency, the Department for Mental Health and Mental Retardation Services. The Title V Agency, (or its contractor state agency, the Department for Mental Health and Mental Retardation Services) must maintain, in auditable form, all records of expenditures for services for which claims of reimbursement are made to the Medicaid agency. Payments to state agencies shall not exceed actual documented costs. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year.

XXV. Advanced Registered Nurse Practitioner Services

(1) Reimbursement

a. Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of a licensed ARNP.

b. Except as specified in subsection c of this section or Section 2 below, reimbursement for a procedure provided by an ARNP shall be at the lesser of the following:
   1. The ARNP's actual billed charge for the service; or
   2. Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.

c. An ARNP employed by a primary care center, federally qualified health center, hospital, or comprehensive care center shall not be reimbursed directly for services provide in that setting while operating as an employee.

(2) Reimbursement Limitations.

a. The fee for administration of a vaccine to a Medicaid recipient under the age of twenty-one (21) by an ARNP shall be three (3) dollars and thirty (30) cents up to three (3) administrations per ARNP, per recipient, per date of service.

b. The cost of a vaccine available free through the Vaccines for Children Program shall not be reimbursed.

c. Injectable antibiotics, antineoplastic chemotherapy, and contraceptives shall be reimbursed at the lesser of:
   1. The actual billed charge; or
   2. The average wholesale price of the medication supply minus ten (10) percent.

d. Reimbursement for an anesthesia service provided during a procedure shall be inclusive of the following elements:
   1. Preoperative and post-operative visits;
   2. Administration of the anesthetic;
   3. Administration of intravenous fluids and blood or blood products incidental to the anesthesia or surgery;
   4. Post-operative pain management; and
   5. Monitoring services.

e. Reimbursement of a psychiatric service provided by an ARNP shall be limited to four (4) psychiatric services per ARNP, per recipient, per twelve (12) months.

f. Reimbursement for a laboratory service provided in an office setting shall be inclusive of:
   1. The fee for collecting and analyzing the specimen; and
   2. Should the test require an arterial puncture or venipuncture, the fee for the puncture.

g. Reimbursement shall be limited to one (1) of the following evaluation and management services performed by an ARNP per recipient, per date of service:
   1. A consultation service;
   2. A critical care service;
   3. An emergency department evaluation and management service;
   4. A home evaluation and management service;
   5. A hospital inpatient evaluation and management service;
   6. A nursing facility service;
   7. An office or other outpatient evaluation and management service;
   8. A preventive medicine service; or
   9. A psychiatric or other psychotherapy service.

XXVI: Federally Qualified Health Center Services

Enrolled Federally Qualified Health Center providers shall be paid full reasonable cost determined in the same manner as for primary care centers except that cost shall not include an incentive payment.

XXIX Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

(1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services), the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:

(a) 1905(a)(1), inpatient hospital services;
(b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
(c) 1905(a)(3), other laboratory and X-ray services;
(d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
(e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
(f) 1905(a)(6), medical care by other licensed practitioners;
(g) 1905(a)(7), home health care services;
(h) 1905(a)(9), clinic services;
(i) 1905(a)(10), dental services;
(j) 1905(a)(11), physical therapy and related services;
(k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
(l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
(m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
(n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
(o) 1905(a)(17), nurse-midwife services;
(p) 1905(a)(18), hospice care;
(q) 1905(a)(19), case management services; and
(r) 1905(a)(22), other medical and remedial care specified by the Secretary.

(2) For medically-necessary evaluative, diagnostic, preventive, and treatment services listed in Section 1905(a) of the Social Security Act included in an Individual Education Program under the provisions of the Individuals with Disabilities Education Act, the state shall pay in accordance with items (1) or (3), as applicable, except that for public providers the payment shall be a fee-for-service system designed to approximate cost in the aggregate without settlement to exact cost. The following describes the methodology utilized in arriving at the rates.

(a) The aggregate will be calculated for all participating public providers in the state. Initial interim rates will be established using data provided by the Department of Education from most of the public providers in the state and data gathered in surveys. During the first year, participating providers will be required to provide data which will be used to calculate final rates; claims paid using the interim rates will be adjusted after final rates have been established. This process will be repeated each state fiscal year as new providers are added and as previously participating providers experience changes with regard to their costs. Through this process, cost in the aggregate will only reflect the cost of participating providers on a statewide basis.

(b) Payments to public providers are based on a statewide fee for each procedure code. A fee for a particular procedure code is based on the lower of the mean or median statewide cost of providing the service. The statewide mean and median cost to participating providers for a service is based on a 100 percent sample of the contracted service cost and/or cost associated with publicly employed professionals. Cost for publicly employed professionals consists of salary, fringe benefits and indirect overhead. Annual professional salaries are converted to hourly wages using 185 work days per year and six (6) work hours per day. For salaried employees the public provider fringe benefit rates for classified employees and for certified employees will be used. Indirect overhead cost computed at the rate of seven (7) percent of hourly wage salaries is added to the hourly wage rate and the fringe benefits to establish their hourly cost.

(c) The mean and median hourly rate is calculated, for each class of qualified professionals, from an array of hourly cost data falling within one standard deviation of the mean. The resultant hourly rates are converted to fifteen (15) minute service units.

(d) The following two (2) exceptions to usual cost reimbursement will be applicable: first, for emergency medical transportation, reimbursement will be based on the average cost per mile of pupil transportation calculated by the Kentucky Department of Education; and, second, for assistive technology, reimbursement will be based on the actual invoiced cost for the IEP authorized equipment. Transportation will be paid based on units of one (1) mile.

(3) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21, the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100 percent of usual and customary

charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

(a) Any service described in one (1), above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
(b) 1905(a)(8), private duty nursing services;
(c) 1905(a)(20), respiratory care services;
(d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and
(e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitariums, and personal care services in a recipient's home.

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XXX. Radiological (X-ray) Services

Payments for radiological services covered pursuant to the mandate contained in 42 CFR 440.30 shall be at usual and customary charges up to sixty (60) percent of the allowable physician fee for the same procedures where the physician is performing both the professional and technical portions of the service.

XXXI. Payment methodology for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and for adults in need of protective services.

A. Targeted case management services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rate for targeted case management is a negotiated rate between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of the service.

The payment rate for a targeted case management service that is authorized after June 30, 2002, is a uniform rate, determined by 98% of the weighted median of claims for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

The billable unit of service is one month

B. Targeted case management services for children under the supervision of the state and for adults in need of protective services.

Payments for targeted case management services for the target populations are monthly. They are based upon one or more documented targeted case management services provided to each client during that month. The monthly rate for the targeted case management services is based on the total average cost per client served by the provider. The monthly rate is established on a prospective basis based upon actual case management costs for the previous year. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing case management services based on financial information submitted by the provider.

Case management providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: directly coded worker time; identification, by recipient and worker, of each individual service provided, a showing of all direct costs for case management activities; and a showing of all indirect costs for case management activities appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principles if necessary.

XXXII. Specialized Children's Services Clinics

Clinic services provided by Specialized Children's Services Clinics will be reimbursed initially at a statewide uniform all-inclusive rate per visit (encounter rate) of $538. This rate is estimated to approximate the average statewide costs of all clinics providing the service. This rate includes the costs of professional services (physician and mental health professional), related costs of providing a sexual abuse exam, and facility costs (overhead). This rate is based on the projected cost of providing the service as submitted to the department by the providers and a consideration of rates paid to providers for similar services.

Providers will submit cost reports annually. Upon receipt of completed cost reports from all clinics, the department will establish a rate within 90 days using updated cost data.

Payments made under this provision shall not exceed the upper limit of payment as specified in 42 CFR 447.325.

XXIII. Targeted Case Management and Diagnostic, Preventive and Rehabilitative Early Intervention Services for children eligible for the Early Intervention program provided through a Title V agreement.

This payment system is for all providers, including those providing services under the Title V agreement described in Supplement 1 to Attachment 4.16-A, Item #10.

All costs shall be determined based on the methodology outlined in OMB Circular A-87. Payments for case management, diagnostic, rehabilitative, and preventive early intervention services shall be made in accordance with a fee schedule established by the Title V agency. Interim payments shall be based on the direct cost of providing the service. Payments for overhead and administrative costs associated with providing the service shall be determined with a settlement to cost at the end of the fiscal year. Providers will submit cost reports no later than 180 days after the end of the state fiscal year.

XXXIV. Rehabilitation Services for Pregnant Women

Substance abuse services covered for pregnant women including postpartum women for a sixty (60) day period after the pregnancy ends and any remaining days in the month in which the 60th day falls, provided by any mental health centers, their subcontractors and any other qualified providers, licensed in accordance with applicable state laws and regulations. Payment for these services will be based on cost in accordance with attachment 4.19-B, pages 20.15-20.15.5.

Reimbursement for services shall be based on the following units of service:

Universal prevention service shall be a one-quarter (1/4) hour unit;
Selective prevention service shall be a one-quarter (1/4) hour unit;
Indicated prevention service shall be a one-quarter (1/4) hour unit;
Outpatient service shall be a one-quarter (1/4) hour unit for the following modalities:

- Individual therapy;
- Group therapy;
- Family therapy;
- Psychiatric evaluation;
- Psychological testing;
- Medication management; and
- Collateral care;

An assessment service shall be a one-quarter (1/4) hour outpatient unit;
Day rehabilitation services shall be a one (1) hour unit;
Case management services shall be a one-quarter (1/4) hour unit; and
Community support shall be a one-quarter (1/4) hour unit;

Targeted case management services for at risk parents during the prenatal period and until the child's third birthday

This payment system is for all providers, including those providing services under the Title V agreement described in Attachment 4.16-A, Item #10.

Payments shall be based on cost. Interim rates based on projected cost shall be used with a settlement to cost at the end of the state fiscal year. Case management providers who are public state agencies shall have on file an approved cost allocation plan.

Interim rates shall be established in the following manner:

1) The rate for the assessment shall be based on the projected cost of providing the service consistent with methodology in OMB Circular A-87. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

2) The rate for the professional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

3) The rate for the family service worker/paraprofessional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

Cost will be accounted for as follows:

1) Case management staff directly related to the targeted case management program will code all direct time using categories designated for case management functions in 15 minute increments.

2) Any contract costs (i.e., for contracted services) will be based on the actual cost of acquisition of the service.

3) Any indirect costs of any public state agency will be determined using the appropriate cost allocation plan.

Providers will submit cost reports no later than 180 days after the end of the state fiscal year. Interim payments will be adjusted to actual cost based upon review and acceptance of these cost reports in accordance with usual agency procedures.